

PRIOR AUTHORIZATION for Cochlear Implants, Auditory Brainstem Implants, & Bone Anchored Hearing Aids (BAHA)

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:
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Section II: PROVIDER(S) INFORMATION

Rendering Provider:			Rendering Provider Address:		
Provider NPI #:	Provider TIN #:	Contact Person:	Phone: ()	Facsimile: ()	Email Address:
Facility/Hospital Name:			Facility/Hospital Address:		
Facility NPI #:	Facility TIN #:	Contact Person:	Phone: ()	Facsimile: ()	Email Address:

Section III: PRE-AUTHORIZATION REQUEST

A. Nature of Request: <i>Please check.</i> <input type="checkbox"/> Auth Extension <input type="checkbox"/> Pre-Auth <input type="checkbox"/> Retro Auth	B. Requested Date(s) of Service: From: To:	C. Place of Service: <i>Please check.</i> <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Inpatient <input type="checkbox"/> Office <input type="checkbox"/> Outpatient
D. Primary Diagnosis/ICD-10 Code (s):		E. Secondary Diagnosis/ICD-10 Code (s):
F. Type of Hearing Device Being Requested: <i>Please check.</i> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> 1. <input type="checkbox"/> Auditory Brainstem Implant (ABI) 2. <input type="checkbox"/> Cochlear Implant without External Hearing Aid 4. <input type="checkbox"/> Hybrid Cochlear Implant with External Hearing Aid 5. <input type="checkbox"/> Implantable Bone Anchored Hearing Aid (BAHA) </div> <div style="width: 48%;"> 6. <input type="checkbox"/> Non-Implantable Intraoral Bone Conduction Hearing Aid (e.g., SoundBite™ Hearing System) 7. <input type="checkbox"/> Partially Implanted BAHA 8. <input type="checkbox"/> Percutaneous BAHA (with Abutment or Magnetic Coupling) 9. <input type="checkbox"/> Other: _____ </div> </div>		

G. Service (s) Requested: *Please list all requested services/codes regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.*

Procedure/Service: _____ CPT/HCPCS code: _____
Please check all that apply: ☐ Bilateral (Both Sides) ☐ Left Side ☐ Right Side ☐ Repair ☐ Replacement ☐ Second/Contralateral ☐ Upgrade

Procedure/Service: _____ CPT/HCPCS code: _____
Please check all that apply: ☐ Bilateral (Both Sides) ☐ Left Side ☐ Right Side ☐ Repair ☐ Replacement ☐ Second/Contralateral ☐ Upgrade

Procedure/Service: _____ CPT/HCPCS code: _____
Please check all that apply: ☐ Bilateral (Both Sides) ☐ Left Side ☐ Right Side ☐ Repair ☐ Replacement ☐ Second/Contralateral ☐ Upgrade

Procedure/Service: _____ CPT/HCPCS code: _____
Please check all that apply: ☐ Bilateral (Both Sides) ☐ Left Side ☐ Right Side ☐ Repair ☐ Replacement ☐ Second/Contralateral ☐ Upgrade

(Please check service being requested.) QUESTION	YES	NO	COMMENTS/NOTES
H. <input type="checkbox"/> Auditory Brainstem Implant (ABI):			
1. Has the patient been diagnosed with Neurofibromatosis Type 2 (NF2)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the patient 12 years old or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Will the patient be undergoing removal of bilateral tumors of the auditory nerves that will leave the patient completely deaf because of the surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Did the patient have removal of bilateral auditory nerve tumors and is now bilaterally deaf?	<input type="checkbox"/>	<input type="checkbox"/>	
I. <input type="checkbox"/> Bone Anchored Hearing Aids (BAHA) – Fully Implantable or Partially Implantable:			
1. Is the patient 5 years old or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the patient have unilateral or bilateral conductive hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the patient have unilateral or bilateral mixed (conductive and sensorineural) hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the patient have any of the following conditions that prevents restoration of hearing using a conventional air-conductive hearing aid? <i>Please check all that apply.</i> <input type="checkbox"/> Congenital or surgically induced malformations of the external ear canal or middle ear (such as aural atresia) <input type="checkbox"/> Dermatitis of the external ear, including hypersensitivity reactions to ear molds used in air conduction hearing aids <input type="checkbox"/> Hearing loss secondary to otosclerosis in persons who cannot undergo stapedectomy <input type="checkbox"/> Severe chronic external otitis or otitis media <input type="checkbox"/> Tumor(s) of the external ear canal and/or tympanic cavity <input type="checkbox"/> Other conditions in which an air-conduction hearing aid is contraindicated	<input type="checkbox"/>	<input type="checkbox"/>	

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Name (Last, First MI):	DOB:	Age:	PEHP ID #:		
(Please check service being requested.)					
QUESTION (cont'd)			YES	NO	COMMENTS/NOTES
5. Is unilateral implant being requested for conductive or mixed hearing loss with pure tone average bone conduction threshold values measured at 0.5, 1, 2, and 3 kHz less than or equal to 45 dB hearing level (HL), 55 dB HL, or 65 dB HL?			<input type="checkbox"/>	<input type="checkbox"/>	
6. Is bilateral implant being requested for moderate-to-severe bilateral symmetric * conductive or mixed hearing loss meeting bone conduction thresholds in both ears in question #5.? <i>*Symmetric bone conduction threshold is defined as a difference of less than 10 dB on average (measured at 0.5, 1, 2, and 3 kHz) or less than 15 dB at any individual frequency between the two ears.</i>			<input type="checkbox"/>	<input type="checkbox"/>	
7. Is implantable BAHA being requested for unilateral sensorineural hearing loss (i.e., single-sided deafness)?			<input type="checkbox"/>	<input type="checkbox"/>	
8. Is implantable BAHA being requested/used for bilateral pure sensorineural hearing loss?			<input type="checkbox"/>	<input type="checkbox"/>	
J. <input type="checkbox"/> Bone Anchored Hearing Aids (BAHA) – Fully Implantable or Partially Implantable Replacement / Upgrade:					
1. Is upgrade or replacement of an existing external speech processor and abutment being requested because the patient's response to their existing components is inadequate to the point of interfering with the activities of daily living?			<input type="checkbox"/>	<input type="checkbox"/>	Completion of section I. questions 1 – 8. also required.
2. Is upgrade or replacement of an existing external speech processor and abutment being requested because the existing device cannot be repaired?			<input type="checkbox"/>	<input type="checkbox"/>	
3. Is replacement of a BAHA and/or its external components being requested because there has been a change in the member's condition that makes the present unit non-functional?			<input type="checkbox"/>	<input type="checkbox"/>	
4. Is improvement expected with a replacement unit?			<input type="checkbox"/>	<input type="checkbox"/>	
K. <input type="checkbox"/> Unilateral or Bilateral Traditional Cochlear Implant without an External Hearing Aid for Bilateral Sensorineural Hearing Loss:					
1. Is the patient one year old or older?			<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there reasonable expectation that a significant benefit will be achieved from the device?			<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the patient have bilateral, severe to profound sensorineural hearing loss defined as a pure tone average of 70 dB (decibels) hearing loss or greater at 500 Hz (hertz), 1000 Hz, and 2000Hz?			<input type="checkbox"/>	<input type="checkbox"/>	
4. Is there documentation that the patient had limited or no benefit from a minimum of 3-month trial of appropriately fitted hearing aids?			<input type="checkbox"/>	<input type="checkbox"/>	
4. a. For children with bilateral sensorineural hearing loss were they unable to undergo a 3-month trial of an appropriately fitted binaural hearing aids because the patient has a history of pneumococcal meningitis that caused the hearing loss?			<input type="checkbox"/>	<input type="checkbox"/>	
4. b. For children with bilateral sensorineural hearing loss were they unable to undergo a 3-month trial of an appropriately fitted binaural hearing aids because there was evidence of cochlear ossification on computerized tomography (CT) scan?			<input type="checkbox"/>	<input type="checkbox"/>	
L. <input type="checkbox"/> Second Traditional Cochlear Implant in the Contralateral (Opposite) Ear: *Completion of section K. also required for second implant.					
1. Does the patient an existing unilateral cochlear implant with a hearing aid in the contralateral (opposite) ear that produces limited or no benefit?			<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there a reasonable expectation that a significant benefit will be achieved from the device?			<input type="checkbox"/>	<input type="checkbox"/>	
M. <input type="checkbox"/> Unilateral Traditional Cochlear Implant without an External Hearing Aid for Unilateral Sensorineural Hearing Loss:					
1. Is the patient one year old or older?			<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there reasonable expectation that a significant benefit will be achieved from the device?			<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the patient have single sided deafness (SDD) with profound sensorineural hearing loss in one ear (pure tone average of 90 dB HL or greater at 500 Hz, 1000 Hz, 2000 Hz, and 4000 Hz) and normal hearing (pure tone average of up to 15 dB HL at 500 Hz, 1000 Hz, 2000 Hz and 4000 Hz) or mild sensorineural hearing loss in the other ear (pure tone average of up to 30 dB HL at 500 Hz, 1000 Hz, 2000 Hz and 4000 Hz)?			<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the patient have asymmetric hearing loss (AHL) with profound sensorineural hearing loss (pure tone average of 90 dB HL or greater at 500 Hz, 1000 Hz, 2000 Hz, and 4000 Hz) in one ear and mild to moderately severe sensorineural hearing loss in the other ear (pure tone average ranging from 31 to up to 55 dB HL at 500 Hz, 1000 Hz, 2000 Hz and 4000 Hz) with a difference of at least 15 dB in pure tone averages between ears?			<input type="checkbox"/>	<input type="checkbox"/>	
5. Is there documentation that the patient had limited or no benefit from a minimum of 1-month trial of appropriately fitted unilateral hearing aid in the ear to be implanted?			<input type="checkbox"/>	<input type="checkbox"/>	
N. <input type="checkbox"/> Replacement of a Traditional Cochlear Implant without an External Hearing Aid: *Completion of Section K. or M. also required.					
1. Is the currently used component no longer functional and cannot be repaired?			<input type="checkbox"/>	<input type="checkbox"/>	
1. a. If the currently used component is no longer functional is their evidence to suggest that the device has been abused or neglected?			<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the currently used component render the implant recipient unable to adequately and/or safely perform their age-appropriate activities of daily living?			<input type="checkbox"/>	<input type="checkbox"/>	
Additional Comments:					
By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.					
*Please fax completed form and medical records to 801-366-7449.					